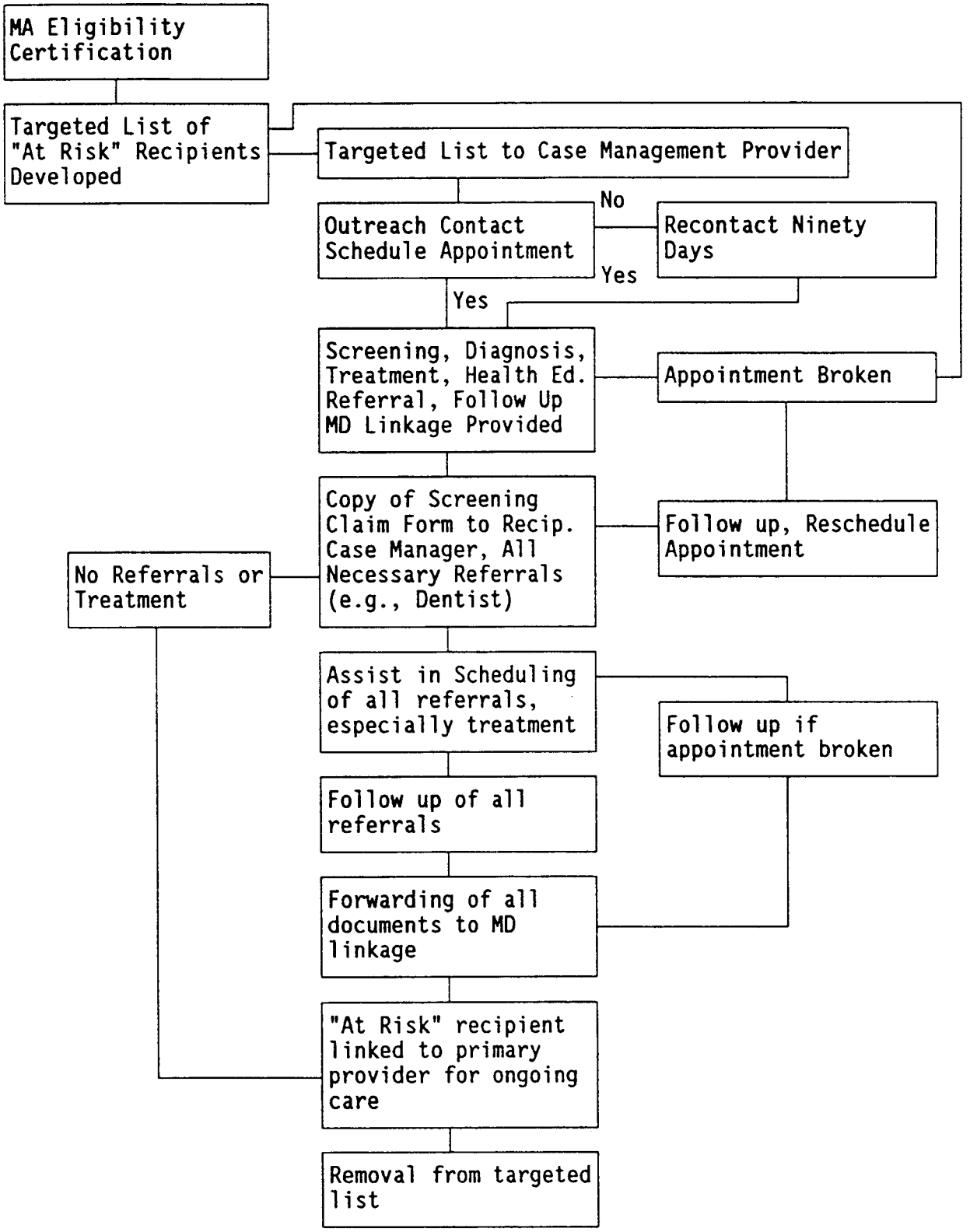
HEALTHCHECK OUTREACH AND CASE MANAGEMENT
APPENDICES

APPENDIX 1

HEALTHCHECK OUTREACH AND CASE MANAGEMENT FLOWCHART OF ACTIVITY



APPENDIX 2
HEALTHCHECK OUTREACH/CASE MANAGEMENT NEED DETERMINATION

Purpose:
The targeted list the provider agency receives prioritizes eligible Medical Assistance recipients who may be in need of outreach and case management. Some recipients may in fact have received a screening or other health care since this list was generated. Therefore, it is critical that the provider determine if the recipient has received health care. Begin with the first prioritized listed recipient. To determine if the recipient is in need of case management, ask the following questions:

1. When was the date the recipient was last screened, or had an extensive physical exam?

   a. If the recipient is under age 2, and was not screened within the past six months, then the recipient is in need of case management.

   b. If the recipient is at least 2 years of age but under 5 years of age, and not screened within the past twelve months, then the recipient is in need of case management.

   c. If the recipient is at least age 5 but under age 21, and not screened within the past 24 months, then the recipient is in need of case management, or if the recipient is pregnant and is not currently receiving prenatal care.

2. Does the recipient have a primary health care provider from whom regular health care is obtained?

   a. If yes, the provider should attempt to link the recipient with the physician for a HealthCheck screening. If this is not possible, or the recipient requests screening services from the outreach and case management provider, then screen the recipient. In either screening situation, case management should be provided.

   b. If no, recipient does not have a primary physician, you may screen and case manage the recipient. The recipient should be linked with a medical assistance certified physician for future care. Screening results should be shared with the physician. If the recipient is age 3 or older, referral should be made to a dentist for examination and ongoing care. The recipient's physician should also know the dentist's name for future screening referral.

3. Conduct inventory needs assessment of the recipient and family as guided by the case management plan.

NOTE: The HealthCheck screening schedule is outlined by the Periodicity Schedule as listed in Appendix 5 of the HealthCheck Screening Services Provider Handbook, Part D, Division I.

Case management claims for reimbursement must document that a screening did occur. This is done via a screening claim or a physician screening provider referral/modifier code on the outreach and case management claim form.

Outreach and case management may also be provided to eligible recipients who are not on a targeted list, but are eligible for Medical Assistance and "in-need" of a screening based on questions 1 and 2 above. The provider may also claim case management reimbursement if screening services are provided to this recipient. Refer to Section II-C of this handbook for information on non-targeted outreach.

APPENDIX 3

HEALTHCHECK FOLLOW-UP NOTES

Recipient Name	MA ID Number	Date Screened

Problem and/or Referral Destination	Date	Notes
PROBLEM #1		
PROBLEM #2		
PROBLEM #3		
PROBLEM #4		

APPENDIX 4a
BILLING EXAMPLE
NON-TARGETED OUTREACH /COMPREHENSIVE SCREEN WITH IMMUNIZATIONS
CLAIM SORT INDICATOR "H"
RECEIVED BY EDS NO LATER THAN 6/30/95

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A	3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M ☐ F ☒		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 609 Willow St.	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐		7. INSURED'S ADDRESS (No., Street)
CITY: Anytown STATE: WI	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐		CITY STATE
ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX	Employed ☐ Full-Time Student ☐ Part-Time Student ☐		ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-Y	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO		a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE			20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V70 0 2. 3. 4.			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 29 95	3	1	W7014	01	1	XX XX	1				
2 01 29 95	3	1	W7000	04	1	XX XX	1				
3 01 29 95	3	1	90701		1	XX XX	1				
4 01 29 95	3	1	W7020		1	XX XX	1				
5 01 29 95	3	1	90712		1	XX XX	1				
6 01 29 95	3	5	85018		1	XX XX	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐	26. PATIENT'S ACCOUNT NO. 1234JD	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $ XXX XX
29. AMOUNT PAID $	30. BALANCE DUE $ XXX XX		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I. M. Authorized SIGNED MM/DD/YY DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I. M. Billing 1 W. Williams Anytown, WI 55555 PIN# GRP# 87654321

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 4b
BILLING EXAMPLE
TARGETED OUTREACH / COMPREHENSIVE SCREEN WITH IMMUNIZATION
CLAIM SORT INDICATOR "P"
RECEIVED BY THE FISCAL AGENT ON OR AFTER 2/15/95
HEALTHCHECK NURSING AGENCY PROVIDER

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [P] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-Y

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V70 0
2.
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 01 95	3	1	W7012		1	XX XX	1				
2 02 01 95	3	1	99392	HC	1	XX XX	1				
3 02 01 95	3	1	W7018		1	XX XX	1				
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JD

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXXX XX

29. AMOUNT PAID $

30. BALANCE DUE $ XXXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
I.M. Authorized
SIGNED MM/DD/YY DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I. M. Billing
1 W. Williams
Anytown, WI 55555
PIN# GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 4c
HEALTHCHECK SERVICE CODES
TARGETED OUTREACH
SCREENING PROVIDED BY ANOTHER PROVIDER
CLAIM SORT INDICATOR 'P'
RECEIVED BY THE FISCAL AGENT ON OR AFTER 2 /15/ 95

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1 MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #) P	CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (VA File #)	GROUP HEALTH PLAN ☐ (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Recipient, Im A	MM DD YY M X F ☐	
5. PATIENT'S ADDRESS (No., Street): 609 Willow St.	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: Anytown / STATE: WI	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐	CITY / STATE
ZIP CODE: 55555 / TELEPHONE (Include Area Code): (XXX) XXX-XXXX	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO / PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V70.0 2. ____ 3. ____ 4. ____		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 25 95	3	1	W7012	1	XX XX	1				
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
☐ ☐	1234JD		$ XX XX	$	$ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Authorized MM/DD/YY		I. M. Billing 1 W. Williams Anytown, WI 55555
SIGNED DATE		PIN# GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 5
OUTREACH/CASE MANAGEMENT PROCEDURE CODES WITH ALLOWABLE CLAIM SORT INDICATOR AND MODIFIERS

"H" Claim Sort Indicator
Effective for Claims Received by the Fiscal Agent
by June 30, 1995

Procedure Code	Description	POS	TOS	Claim Sort	Modifiers
W7012	Targeted Outreach/Case Management	0,2,3,4	1	H	01-07, 09-12, 14-20
W7014	Non-targeted Outreach/ Case Management	0,2,3,4	1	H	01-07, 09-12, 14-20

OR

"P" Claim Sort Indicator
Effective for Claims Received by the Fiscal Agent
on and after 2 /15 /95

Procedure Code	Description	POS	TOS	Claim Sort	Modifiers
W7012	Targeted Outreach/Case Management	0,2,3,4	1	P	None
W7014	Non-targeted Outreach/ Case Management	0,2,3,4	1	P	None

APPENDIX 6
HEALTHCHECK SERVICES CODES

ALLOWABLE PLACE OF SERVICE

Code	Description
0	Other
2	Outpatient Hospital
3	Office
4	Home

ALLOWABLE TYPE OF SERVICE

Code	Description
1	Medical
5	Lab
9	Other

NOTE: Refer to Appendix 18, 18a and 18b of Part D, Division I, of the HealthCheck Handbook to identify allowable place of service and type of service codes for specific HealthCheck procedure codes.